(8)

No. 85-632

Supreme Court, U.S.
FILED
MAR 5 1986
JOSEPH F. SPANIOL, JR.
CLERK

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,

Petitioner,

v.

SANTOS RIVERA, et al.,

Respondents.

ON WRIT OF CERTIORARI TO THE SUPREME
JUDICIAL COURT OF MASSACHUSETTS

BRIEF AMICI CURIAE OF THE GRAY PANTHERS ADVOCACY COMMITTEE, EVELYN ALLEN, AND KATHLEEN IGNOTZ IN SUPPORT OF RESPONDENTS' POSITION

Eugenie Mitchell
Gill Deford
National Senior
Citizens Law Center
1052 W. 6th Street
7th Floor
Los Angeles, CA 90017
(213) 482-3550

Roger A. Schwartz
Judith G. Waxman
National Health
Law Program
2025 M Street, N.W.,
Suite 400
Washington, D.C. 20036
(202) 887-5310

Attorneys for Amici Curiae

55pp

EDITOR'S NOTE

THE FOLLOWING PAGES WERE POOR HARD COPY AT THE TIME OF FILMING. IF AND WHEN A BETTER COPY CAN BE OBTAINED, A NEW FICHE WILL BE ISSUED.

TABLE OF CONTENTS

Page

TABLE OF CONTENTS i

TABLE OF AUTHORITIES ii

BRIEF AMICI CURIAE 1

Interests of Amici 1

Summary of Argument 5

ARGUMENT

I. A One-Month Spenddown Is Administratively Simple In States Now Employing It 7

II. The Adverse Effect of a Six-Month Spenddown on Medically Needy Applicants/Recipients . . . 19

A. Impact on Specific Individuals 19

B. A Six-Month Spenddown Is Not Responsive to the Neediest Applicants/Recipients 30

III. Cut backs in Government Health Assistance Exacerbate the Adverse Effect of a Six-Month Spenddown 39

TABLE OF AUTHORITIES

Cases: Page

Allen v. Petit,
Civ. No. 85-0025P
(D.Me. June 3, 1985) 3

Brogan v. Miller,
537 F. Supp. 139 (N.D. Ill. 1982) . 25
26,28

Coleman v. Miller,
No. 82-C-6259 (N.D.Ill. 1984) . . . 17

DeJesus v. Perales,
770 F.2d 316 (2d Cir. 1985),
petition for certiorari docketed
No. 85-6337 (U.S. Feb. 7, 1986). . 5,7
28,29

Hogan v. Heckler,
597 F. Supp. 1106 (D.Mass., 1984),
rev'd, 769 F.2d 886 (1st Cir., 1985),
petition for certiorari docketed
No. 85-6386 (U.S. Feb. 14, 1986) . .3,5
21,23,25

Schweiker v. Gray Panthers,
453 U.S. 34, 40 (1981) 2

Statutes:

42 U.S.C. §1396p(c) 34

Page

Act of July 4, 1976, ch. 126, §11, 1976 Cal. Stats. (enacting Cal. Welf. & Inst. Code §14005.9 (1976)); see also current Cal. Welf. & Inst. Code §14005.9(a) . . . 8

Act of June 28, 1981, ch. 102, §100, 1981 Cal. Stats. (amending Cal. Welf. & Inst. Code §14005.9 (1981)) 8

Act of June 30, 1982, ch. 328, 1982 Cal. Stats.; Act of Sept. 30, 1982, ch. 1594, 1982 Cal. Stats. 9

Act of Sept. 30, 1982, ch. 1594, §20, 1982 Cal. Stats. (amending Cal. Welf. & Inst. Code §14005.9(a)) . .8,9

Cal. Welf. & Inst. Code §§14005.7 and 14005.12. 9

Regulations:

42 C.F.R. §§433.135 et seq (Third Party Liability), portions of which are amended at 50 Fed. Reg. 46664-46666 (Nov. 12, 1985) 33

42 C.F.R. §435.831(c)(1). 33

22 Cal. Admin. Code §50189(a) 11

22 Cal. Admin. Code §50191(a) 11

22 Cal. Admin. Code §50653 9

22 Cal. Admin. Code §§50653.5 and 50653.3 11

22 Cal. Admin. Code §50657(2)(A) 10

22 Cal. Admin. Code §50658(a) 10

22 Cal. Admin. Code §50658(c)(3)(d) . . 10

Hawaii Administrative Rules 17-744-71, Cost Sharing of Medical Care Costs . . . 12

Mass. Dept of Public Welf., 106 CMR, §505.110 (Rev. 11/85) 32

Mass. Dept. of Public Welfare, 106 CMR §505.120 34

Mass. Dept. of Public Welfare, 106 CMR §505.160 33

Miscellaneous

Annas, George J., "Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards," American Journal of Public Health," Vol. 76, No. 1, January, 1986 45

Page

Bernard, "Patient Dumping:
A Resident's Firsthand View"
34 The New Physician, 323
(October, 1985) 44

Engel, M., "Hospitals Refusing
to Admit Poor: Patients Transferred
to D.C. General," Washington Post
(October 15, 1984) 44

Feder, Judith et al., "Falling
Through the Cracks: Poverty,
Insurance Coverage & Hospital Care
for the Poor 1980 & 1982." Milbank
Memorial Fund Quarterly Health & Society,
62(4): 544-566, Fall 1984. 43

"Health and Welfare; Medi-Cal Reform,"
14 Pacific Law Journal 645 (1982). 9

Howell, Corder, and Dobson,
"Out of Pocket Health Expenses For
Medicaid Recipients & Low Income Persons
1980." National Medical Care
Utilization & Expenditure Survey.
Series B Descriptive Report #4.
DHHS Pub. #85-20204. Office of
Research & Demonstration, HCFA.
Washington, D.C., U.S. Government
Printing Office, August 1985. 42

Page

Illinois Dept. of Public Aid Bureau of Management and Budget, "Medical Assistance Expenditures by Recipient Category FY 83 - FY 85" (as cited in Resp. Opp. to Pet. for Writ of Cert., at 6 n**.). 17

Illinois Department of Public Aid, Official Memorandum, issued May 15, 1984. 14

Social Statistics, Monthly Summary, NYS Dept. of Social Services (9/11/85), p. 5, Table 5. 19

Statement of Ray Newman, Executive Vice President and Chief Operating Officer, Dallas County Hospital District before the Subcommittee on Health, Committee on Finance, U.S. Senate, Sept. 28, 1984, p. 22. 44

Unpublished data from Health Care Financing Administration, Office of Management and Budget, Institute for Research on Poverty, and the Brookings Institute. 41

Urban Systems Research and Engineering, Evaluation of Medicaid Spend Down at 63-64 and 157 (1976). . . .39

Page

U.S. Bureau of the Census,
1984 Current Population Survey. 40

U.S. Department of Commerce,
Bureau of the Census, Characteristics
of the Population Below Poverty.
Current Population Reports.
Series P-60, No. 138, March 1983.
Money Income and Poverty Status of
Families and Persons in the United
States, 1983. Current Population
Reports. Series P-60, No. 145,
August 1984. 41

U.S. Department of H.H.S., P.H.S.,
N.C.H.S.R., Health Characteristics.
According to Family & Personal Income,
United States Data from the National
Health Survey Series, 10, No. 147,
January, 1985. 41

Updated Report on Access to
Health Care for American People,
Special Report, No. One Princeton,
N.J.: The Robert Wood Johnson
Foundation, 1983. 40,42

No. 85-632

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,
Petitioner,

v.

SANTOS RIVERA, Madeline McKenna,
and all others similarly situated,

Respondents.

BRIEF AMICI CURIAE ON BEHALF OF THE GRAY PANTHERS ADVOCACY COMMITTEE, EVELYN ALLEN, AND KATHLEEN IGNOTZ

INTERESTS OF AMICI CURIAE

The Gray Panthers Advocacy Committee, Evelyn Allen and Kathleen Ignotz are amici curiae in support of respondents

Rivera and McKenna and the class of Medicaid recipients they represent in this case.

The Gray Panthers Advocacy Committee is a committee of the Gray Panthers, a national organization comprised of 40,000 individuals who reside throughout the United States. "[D]edicated to helping the Nation's elderly," Schweiker v. Gray Panthers, 453 U.S. 34, 40 (1981), its members seek to reform and improve various laws and institutions which affect the lives of America's elderly, many of whom are Medicaid recipients. The Advocacy Committee itself has 30 to 40 low-income members who, from time to time, need Medicaid benefits and who suffer variously from lengthy spenddown periods in their different states.

Evelyn Allen is a sixty-one-year-old disabled woman residing in Bridgton, Maine, who lives on very modest Social Security and alimony payments. Ms. Allen is sometimes forced to forego needed medical attention for her emphysema during the period when she must reach a $900 spenddown which Maine requires for her to be eligible for Medicaid. Ms. Allen successfully challenged Maine's six-month Medicaid spenddown rule (Allen v. Petit, Civ. No. 85-0025P (D.Me. June 3, 1985)), only to have her victory crumble when the First Circuit ruled in Hogan v. Heckler, 769 F.2d 886 (1st Cir., 1985), petition for certiorari docketed No. 85-6386 (U.S. Feb. 14, 1986). If the Court in this case holds in respondents' favor, Ms. Allen stands to gain the reinstatement of her earlier success and,

more importantly, to achieve much-needed access to necessary medical care for her respiratory illness.

Kathleen Ignotz, a resident of Wheeling, West Virginia, suffers from chronic asthma and depends on consistent administration of steroids for successful treatment. Despite Ms. Ignotz' meager income of Social Security benefits and part-time wages, West Virginia's use of a six-month spenddown has resulted in her having to spend down amounts up to $876 before she could qualify for Medicaid. Because of the State's six-month spenddown period, Ms. Ignotz was left with a hospital bill in excess of $700 in 1985 -- a bill which would have totaled $133 if the State employed a one-month spenddown. Because of these inequities, Ms. Ignotz was prepared to sue West

Virginia to invalidate its six-month spenddown rule. However, the advent of the First and Second Circuit rulings in Hogan v. Heckler, supra, and DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985), petition for certiorari docketed No. 85-6337 (U.S. Feb. 7, 1986) deterred her from doing so. If the Court in this case affirms the decision below invalidating a six-month spenddown, Ms. Ignotz' ability to receive Medicaid coverage in the future will improve substantially.

SUMMARY OF ARGUMENT

Amici defer to Respondents' Brief for full argument of the legal issues in this case. Amici focus their Brief, instead, on three directly relevant aspects of this case:

1. The administrative rationality and workability of a one-month spenddown rule -- as demonstrated by the states which employ such a spenddown.

2. The adverse effect of a six-month spenddown on medically needy applicants and/or recipients -- as demonstrated a.) by reviewing he circumstances of several of the individual plaintiffs in cases similar to this action, and b.) by illustrating how the six month spenddown fails to target many of the neediest applicants.

3. The six-month spenddown's exacerbation of the presently increasing difficulty that the poor have in getting access to health care.

ARGUMENT

I. A One-Month Spenddown Is Administratively Simple In States Now Employing It.

Amici believe that there are a total of six states that either use a one-month spenddown period or allow recipients to choose a spenddown period varying in length from one to six months. They include large and populous states such as California and Illinois, as well as less populous states such as Hawaii, North Dakota, Utah, and South Carolina. In addition, New York allows a one month spenddown for ambulatory services but requires a six month spenddown for hospital care. See DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985). A brief description of the administration of the one-month spenddown in several of these states supports the conclusion that such a rule is not administratively burdensome.

California. California has the highest number of Medicaid recipients of any state in the nation, yet, it has almost exclusively used a one-month spenddown rule since 1976.[1] Only during a brief period of about fifteen months in 1981-82, did California use a longer three-month spenddown period.[2] California changed its spenddown period back to one month in 1982.[3] California's fiscal concerns with the one-month spenddown period could not have

---

1 See, Act of July 4, 1976, ch. 126, §11, 1976 Cal. Stats. (enacting Cal. Welf. & Inst. Code §14005.9 (1976)); see also current Cal. Welf. & Inst. Code §14005.9(a).

2 Act of June 28, 1981, ch. 102, §100, 1981 Cal. Stats. (amending Cal. Welf. & Inst. Code §14005.9 (1981)).

3 Act of Sept. 30, 1982, ch. 1594, §20, 1982 Cal. Stats. (amending Cal. Welf. & Inst. Code §14005.9(a)).

been great; it reenacted the one-month limit at the same time as it thoroughly revamped its entire Medicaid system to include many severe cost-containment measures.[4]

The one-month spendown is easily administered in California. The medically nedy income level (MNIL) is a calculation based on an individual's or a family's non-medical needs for one month.[5] Upon application, each beneficiary's income is determined, and the appropriate MNIL is subtracted. The balance is his or her spenddown for that month.[6]

---

[4]Act of June 30, 1982, ch. 328, 1982 Cal. Stats.; Act of Sept. 30, 1982, ch. 1594, 1982 Cal. Stats.; see also, "Health and Welfare; Medi-Cal Reform," 14 Pacific Law Journal 645 (1982).

[5]Cal. Welf. & Inst. Code §§14005.7 and 14005.12.

[6]Id.; 22 Cal. Admin. Code §50653.

The beneficiary receives a form shortly before a new month begins indicating the amount of the spenddown for the succeeding month.[7] The beneficiary carries this form to his or her physician, pharmacist or other medical services provider for documentation of bills paid or incurred up to the spenddown amount. Id. Once the spenddown amount is reached, the beneficiary submits the form to the local welfare office.[8] A Medicaid identification card is then mailed to the beneficiary within a matter of days, or if the beneficiary will need medical services before the mailed card arrives, he or she may obtain a temporary card from the welfare office.[9] Provision is

[7] 22 Cal. Admin. Code §50657(2)(A).

[8] 22 Cal. Admin. Code §50658(a).

[9] 22 Cal. Admin. Code §50658(c)(3)(d).

easily made for increased or decreased income and for over- or under-calculation of spenddown.[10] Beneficiaries are required to complete and return status reports concerning eligibility factors every three months;[11] but face-to-face interviews for the overall redetermination of eligibility only occur annually.[12]

Hawaii. Hawaii has chosen to use a one-month spenddown program since 1979, when beneficiaries complained that applicants with reoccurring monthly bills were experiencing difficulty becoming

---

[10] 22 Cal. Admin. Code §§50653.5 and 50653.3.

[11] 22 Cal. Admin. Code §50191(a).

[12] 22 Cal. Admin. Code §50189(a).

eligible.[13] Hawaii's system is quite similar to that of California and is equally simple.

The MNIL is calculated on a one month basis.[14] An initial determination is made for each applicant as to his or her income eligibility and spenddown amount for each month. Once the beneficiary is notified of his or her spenddown amount, the beneficiary must submit to the local caseworker documentation of medical bills which have been incurred. The caseworker

---

13 Telephone conversation, February 3, 1985, between Earl Motooka, Medicare Care Administrator, Department of Social Services & Housing, State of Hawaii, and J. Waxman, counsel for amici. The following description of the one-month spenddown program in Hawaii is based on this same conversation.

14 Hawaii Administrative Rules 17-744-71, Cost Sharing of Medical Care Costs.

has the authority to determine if the spenddown amount has been met for the month and to issue a Medicaid coupon which is valid for the remainder of the month. Each month, the beneficiary must accumulate documentation for incurred medical expenses and mail or take it to the caseworker who can issue coupons validating eligibility. Redeterminations of income and spenddown are made every six months for AFDC-related beneficiaries and every year for SSI beneficiaries. Applicants who receive an initial income determination but do not utilize the program for three consecutive months are terminated from the Medicaid rolls after proper notice. These individuals may seek redeterminations. The state does not view this system as administratively burdensome.

Illinois. Illinois also uses a MNIL based on one month's income. Under this plan,[15] applicants are given an initial determination of their income eligibility and monthly spenddown amount. The beneficiary is enrolled in the Medicaid program for a six-month period. The beneficiary has the responsibility of presenting documentation of incurred medical bills to the local caseworker who in turn determines eligibility. The caseworker verifies the documentation to determine if the bills equal the spenddown amount for one month. If so, the individual is granted eligibility for the remainder of the month.

---

15 All elements of Illinois' plan described herein can be found in Illinois Department of Public Aid, Official Memorandum, issued May 15, 1984.

Additionally, if the beneficiary has bills which are greater than one month's spenddown, eligibility can be granted for extra months up to a total of six months. The number of months an applicant will be eligible depends on how many months of spenddown the documented medical bills cover. This system allows individuals the opportunity to obtain Medicaid coverage for up to five additional months beyond the initial month of eligibility.

Also, a beneficiary whose medical bills do not allow eligibility for all six months at the outset of the enrollment period, can submit additional bills within the six-month enrollment period to establish eligibility for additional months. At the end of the enrollment period, the beneficiary must

reapply to have the income eligibility and spenddown amount redetermined.

Although the caseworker in this system redetermines eligibility, he or she does not have the authority to issue a Medicaid card, as in Hawaii. Rather, the card is mailed to the recipient. A temporary card can be issued by the caseworker in certain circumstances, if requested. This system does not appear to create an unworkable administrative burden on the State.

In addition to its administrative viability, the use of a one-month spenddown does not necessarily threaten substantial increases in a state's Medicaid costs. As noted in Respondents' Opposition to Petition for Writ of Certiorari in this case, the Illinois

Medicaid budget for the AFDC-type medically needy did not increase significantly after the change from six-month to one-month budgeting required by the Court decision in Coleman v. Miller, No. 82-C-6259 (N.D.Ill. 1984). For the AFDC-related medically needy, the pre-Coleman Fiscal Year 1983 expenditures totaled $35,610,000, while for Fiscal Year 1985, the first full post-Coleman year, they totaled $36,501,000 -- a 2.5% increase.[16]

New York State, in its Amicus Brief in this case, estimates that implementation of a one month spenddown would result in an annual increase of

---

16 Illinois Dept. of Public Aid Bureau of Management and Budget, "Medical Assistance Expenditures by Recipient Category FY 83 - FY 85" (as cited in Resp. Opp. to Pet. for Writ of Cert., at 6 n**.)

between $25 million and $30 million in costs relating to the State's existing case load. Amicus Brief of New York State at 2-3. It also estimates that a one-month spenddown would result in $78 million in additional expenditures for those not presently receiving medical assistance who would become Medicaid-eligible. Id. at 3. It is not clear whether this latter figure is an annual estimate, but assuming it is, and assuming the accuracy of these estimates, the state's worst case scenario calls for an annual increase of $108 million in medical assistance. While Amici by no means minimizes the importance of such an increase in expenditures, it is also important to put such increases in perspective. New York State's monthly medical assistance expenditures between

January and April, 1985 averaged $558,135,554 -- which implies a yearly total of almost $6.7 billion.[17] New York State's worst case predicted increase ($108 million) due to implementation of a one month spenddown, therefore, would constitute less than 1.7% of the State's probable Medicaid expenditure for FY 1985.

II. The Adverse Effect of a Six-Month Spenddown on Medically Needy Applicants/Recipients

A. Impact on Specific Individuals

In briefing in the lower courts, as well as briefing before this Court, Petitioners and Respondents aptly describe

---

[17] Social Statistics, Monthly Summary, NYS Dept. of Social Services (9/11/85), p. 5, Table 5.

the workings of the Medicaid program and particularly the six month medically needy spenddown rule. In essence, the spenddown functions as a large deductible which the applicant must reach before he or she can receive Medicaid coverage. Amici believe it would be of value to this Court to have before it several varied examples of how the six-month spenddown impacts on individual Medicaid applicants -- examples which are readily available by reviewing the legal papers filed or decisions issued in other cases challenging the legality of a multi-month spenddown. A brief review of these cases, demonstrates that the six-month spenddown rule is one that wreaks havoc on medically needy individuals who frequently are more destitute, in terms of income available for health care, than their SSI and AFDC counterparts.

1. DON CARTER

Don Carter, the original plaintiff in Hogan v. Heckler, 597 F. Supp. 1106 (D. Mass., 1984), rev'd 769 F.2d 886 (1st Cir. 1985), petition for certiorari docketed No. 85-6386 (U.S. Feb. 14, 1986), a case involving SSI-related medically needy recipients, was injured by a six month spenddown. As explained by the District Court, at 597 F. Supp. 1109, Mr. Carter required the services of a personal care attendant (P.C.A.). He was a quadraplegic. Mr. Carter's income at the time this suit was filed totalled $743.76 per month. His P.C.A. services cost $875.27. Massachusetts calculated his "excess" income at $390.76 per month which meant that he had to incur about $2300 (six times his monthly excess) before he would be eligible for Medicaid. Ibid.

The District Court explained the effect of the State's policy on Mr. Carter:

> The Department's policy leaves Mr. Carter with two options. He can go begging for credit, trying to find a P.C.A. who is willing to work for months without getting paid. Mr. Carter was successful at this for awhile, but on the evening of November 1, 1982, his P.C.A., having gone unpaid for the three previous weeks, abandoned him. Mr. Carter's second option is to obtain higher medical care so that his "excess" income is spent down faster. This is what he ended up doing, although not by choice. After he was abandoned by his P.C.A., Mr. Carter was admitted for emergency care at the Western Massachusetts Hospital, where he remained for two months while his expenses caught up with the Department's projection of his income. The cost of the Department's six-month spenddown policy is measurable, therefore, both in terms of its potentially devastating impact on a human being, as well as by predictably higher

> expenditures of tax dollars for persons like Mr. Carter who are forced into high-cost institutional care.

597 F. Supp. at 1109.

Had the State employed a one-month spenddown for Mr. Carter, he could have remained home, retained the services of his P.C.A. and cost the State less for his coverage. Indeed, the District Court in Hogan pointed out that the Massachusetts' Department of Public Welfare, the very Petitioner in the case before this Court, recognized the problems of people like Mr. Carter and proposed a "targeted" one-month spenddown for the chronically ill and disabled. Ibid. The District Court noted that Petitioner submitted a request for Federal waiver to enable implementation of such a project. In doing so, Petitioner argued that a six month spenddown policy:

may well impose a hardship on many chronically ill and disabled individuals who require medical services on a daily, weekly or monthly basis in order to remain in the community. It may be extremely difficult or impossible for many of these individuals to both pay medical expenses sufficient to meet their six-month spenddown and maintain funds needed for food, shelter, and family support. They may instead find themselves having to choose between: foregoing necessary non-institutional medical care; submitting to costly and inappropriate hospitalization in order to incur medical expenses in excess of the six-month spenddown liability; or entering a nursing home in order to receive Medicaid coverage via a one-month spenddown. All of these options are ultimately more costly, both socially and economically. The individual is forced by financial imperatives either to physically suffer or to submit to unnecessarily intensive or restrictive inpatient care, the cost of which will likely be borne by Medicaid and Medicare.

Department of Public Welfare, Preventing Unnecessary Institutionalization of the Chronically Ill and Disabled: A One Month Spenddown Program, iv-v (July 5, 1984).

597 F. Supp. at 1109, n. 7.

2. GLADYS ALLISON

The plight of individuals subjected to the six-month spenddown provision also was clear to the Federal District Court in Brogan v. Miller, 537 F. Supp. 139 (N.D. Ill. 1982). In that case, the Court stated:

> There is no dispute that such a policy imposes a real and immediate hardship for members of the plaintiff class. The hardship arises from the requirement that a [medically needy] applicant must anticipate six months' worth of income to calculate his or her spenddown obligation but is not permitted to anticipate six months' worth of medical expenses to offset that income. A [medically needy] applicant who has only one month of income, for example,

> will be required to incur medical expenses to offset six months' worth of "excess" income before qualifying for Medicaid benefits. Under such a policy, individuals in plaintiffs' class will be presented with a "Hobson's choice" of delaying needed medical care in order to pay for other necessities as reflected in the state income eligibility standard or delaying the purchase of those necessities in order to pay for medical care and subsequently qualify for Medicaid.

Id., at 142. The Brogan Court then illustrated, in a footnote, the affect of the spenddown on Gladys Allison, of the plaintiffs in that action:

> The human cost of such a policy can be measured from the experience of Gladys Allison, a seventy-three year old [medically needy] recipient who suffers from chronic Lupus Erythematosus. Although Ms. Allison has available monthly income of only $312.20, [Illinois'] new policy will deny her Medicaid

benefits until she has incurred medical expenses totalling $295.20. In light of her present condition, her foreseeable medical expenses will total at least $175.00 per month. If she chooses to obtain all the medical care she requires, Ms. Allison will incur medical expenses totalling $175.00 in the first month and at least $120.20 in the second month before qualifying for Medicaid. Because of her precarious financial condition, Ms. Allison cannot obtain such medical care on credit. Accordingly, she will have only $137.20 left over to meet her living expenses in the first month and $192.00 in the second month. The State of Illinois has determined that at least $238 is needed each month to pay for the necessities of life (excluding medical care). Alternatively, if Ms. Allison chooses to obtain the necessities of life as defined by the state, she will have only $74.20 left over to pay for needed medical care in the first month this policy takes effect. This amount represents less than half of the total care she requires.

> This result is unconscionable. Lupus Erythematosus is a chronic disease which can be fatal unless the patient is carefully treated and monitored. Affidavit of Dr. Jerome Frankel, ¶3.

Id., at 142 n. 6.

3. GLORIA DEJESUS

The adverse impact of the six-month spenddown is by no means limited to SSI-related (elderly, blind, or disabled) medically needy recipients. In addition to the circumstances of the Respondents in this action, this Court might look to the appellee's circumstances in DeJesus v. Perales 770 F.2d 316 (2d Cir. 1985), petition for certiorari docketed No. 85-6337 (U.S. Feb. 7, 1986). In the Brief for Appellees submitted to the U.S. Court of Appeals for the Second Circuit, Gloria DeJesus, her husband and children,

are described as having, in 1984, a total monthly income of $729.77, consisting of Social Security disability and worker's compensation.[18] Ms. DeJesus and her children were calculated to have $151 per month in excess income in 1984 and, $154 in 1985. However, the State of New York requires a six month spenddown for inpatient hospital bills, consequently the DeJesus' spenddown for medical hospital coverage totaled $918 in January 1985.

This spenddown liability, nearly $200 more than their monthly income, posed a substantial barrier to health care access for Ms. DeJesus and her 7 year old daughter. Operations for both of these

---

[18] The description of the DeJesus' circumstances is taken from the Brief for Appellees submitted in DeJesus v. Perales, supra.

individuals had to be cancelled at one hospital in 1984 when the DeJesus' were unable to pay a preadmission deposit of $906 (their six-month spenddown liability for inpatient hospital care in October 1984.) Similar cancellations occurred the following month at a second hospital. Only after Ms. DeJesus' attorneys advised the hospital of impending litigation on the six-month spenddown provision, was Ms. DeJesus able to have surgery performed in late November, 1984, upon payment of a $151 one-month spenddown.

B. A Six-Month Spenddown Is Not Responsive to the Neediest Applicants/Recipients

It is clear from the descriptions in the previous subsection that a six month spenddown results in a grave hardship to medically needy applicants. Petitioner's Brief and the Amicus Brief of the United

States both maintain, however, that six-month spenddown more accurately focuses scarce resources on those who have the greatest need for assistance because medical costs determined over a six-month period are a more persuasive indicia of hardship than medical costs incurred in any one month period. Petitioners Brief at 17, United States Amicus Brief at 16-17. Indeed, Petitioners take their argument to an extreme by maintaining that a one-month spenddown period will raise the flood gates through which will flow thousands of (presumably) middle income "medically needy" who have cancelled their health insurance, and timed all of their medical ills to occur in the same month, and are now poised to exploit the Medicaid medically needy program.

This latter proposition by Petitioners does not require extensive rebuttal. Amici would only point out that those who would attempt such an exploitation will be both surprised and chagrined when they learn of the resource limitations that are also part of the medically needy program. For example, in Massachusetts an individual who would make use of the medically needy spenddown program is allowed $2,000 in nonexempt assets ($3000 for a two person filing unit, and $100 more for each additional person beyond two).[19] Countable assets generally include cash, bank deposits, IRAS, Keough Plans, Pension Funds, stocks, bonds, money market funds, promissory notes, other financial

---

19 Mass. Dept of Public Welf., 106 CMR, §505.110 (Rev. 11/85).

instruments, all but one (exempt) vehicle, cash surrender value of life insurance policies, and real estate other than principle place of residence.[20]

It is difficult to believe that many (if any) would cancel their health insurance,[21] engage in financial planning, and be prepared to dispose of their excess resources in order to qualify for the medically needy spenddown program. Moreover, even if an individual were bent on such a scheme he would risk

---

20 Mass. Dept. of Public Welfare, 106 CMR §505.160.

21 Cancellation of health insurance would appear to be a particularly foolish action, since the cost of health care premiums can be applied to the spenddown. 42 C.F.R. §435.831(c)(1). Such health insurance would then be applied to cover the cost of medical bills prior to Medicaid's covering these costs. See, 42 C.F.R. §§433.135 et seq (Third Party Liability), portions of which are amended at 50 Fed. Reg. 46664-46666 (Nov. 12, 1985).

running afoul of Medicaid transfer of asset prohibitions common in many states which presume that certain assets transferred (at less than fair market value) by an individual prior to applying for Medicaid, were transferred for the purpose of qualifying for Medicaid.[22] Based on that presumption, these provisions prohibit Medicaid eligibility for extended periods of time. Indeed, if an individual of means was prepared to take such financially desperate steps to become eligible for the medically needy program, it is also possible that the length of the spenddown period, were it one month, three months, or six months, would not dissuade him.

---

22 See 42 U.S.C. §1396p(c). The relevant regulations in Massachusetts can be found at Mass. Dept. of Public Welfare, 106 CMR §505.120.

In reality, of course, potential candidates for the medically needy program are not people of means but those living in varying degrees of poverty.[23] And within this framework, it is not at all clear that a six-month spenddown more precisely targets the poorest members of this population. For example, Petitioners argue that an applicant with $100 in excess monthly income, and medical expenses in excess of $600 over a six month period, is more needy than one such as Ms. Rivera with $314 in medical expenses over six months time even if the entire $314 is incurred in one month. Brief for the Petitioner at 17. This very example, to some degree, undercuts Petitioner's argument. The hypothetical applicant, in Petitioner's example, as

---

[23] See Section III, infra, for further discussion on this point.

with the actual individuals described in the previous section of this Brief will not receive Medicaid assistance until $600 in medical bills has been incurred even if that total is not reached until the 4th, 5th or 6th month of the spenddown period. Alternatively, an individual with an unusually high medical bill in the first month of a six-month spenddown period will become eligible for Medicaid during that first month and remain on the program the remaining five months although medical costs during that period may be minimal. In other words, the advantage of a one month spenddown, is that it targets medically needy coverage for the period of time during which it is needed. In a month when medical bills are high, the applicant gets assistance in meeting those bills

for that month (but not for the remaining months); if medical bills are low that month, the spenddown is not reached, and no assistance is provided; if an individual has high medical bills each month, he or she receives aid each month.

The real strength of a one-month spenddown period in more effectively targeting the neediest, however, relates to the difficulty low-income people have in getting credit. An individual with a $600 six month spenddown may need to incur $600 in medical bills on credit before reaching his or her spenddown. That same individual with a $100 one-month spenddown need attain only $100 in credit before receiving medically needy assistance. As discussed in more detail in the following section, (and noted in several of the individual cases

illustrated in the previous subsection), the ability to get health care on credit is difficult for the poor. Many with a large six-month spenddown simply will not reach (and may eventually not even attempt to reach) their spenddown because of the amount of credit they would have to have extended to them. As a result, households that need to incur relatively low medical costs in order to receive preventative or ambulatory care, are less likely to reach a six month spenddown and are more apt to incur such a large spenddown only as a result of more costly hospital or emergency room treatment -- treatment that might have been avoided if they had not had to forego more timely preventative care due to their inability

to reach the spenddown.[24] Additionally, the longer spenddown period obviously presents a potentially life-threatening problem for those with chronic medical needs or conditions -- such as epileptics who need Dilantin, or diabetics who need insulin -- who are unable to get Medicaid because they cannot meet the large spenddown period quickly enough.

III. Cut Backs in Government Health Assistance Exacerbate the Adverse Effect of a Six-Month Spenddown.

Poor people always have had to struggle to receive proper health care. In the current atmosphere of cost

---

24 One study has shown that, on average, 10% of unsuccessful spend down applicants are prevented from becoming eligible because of the cash flow problem of a six-month accounting period. Urban Systems Research and Engineering, Evaluation of Medicaid Spend Down at 63-64 and 157 (1976).

containment and competition, that struggle has intensified. Thus, between 1979 and 1984 those without any kind of health insurance have increased 22.3% from 28.7 to 35.1 million Americans.[25] There is substantial evidence that many of these people "fall through the cracks" of the health care system.[26] Those who are the most at risk are people who are too poor to buy health insurance and do not qualify for Medicaid and yet are sick. Poor people are not only more likely to not have insurance they are also more likely to be sick. Studies show that the poor are four times more

---

25 U.S. Bureau of the Census, 1984 Current Population Survey.

26 Updated Report on Access to Health Care for American People, Special Report, No. One Princeton, N.J.: The Robert Wood Johnson Foundation, 1983.

likely to be in fair or poor health than non-poor people.[27]

Yet traditional sources of health care coverage have been reduced. According to a Robert Wood Johnson study the proportion of the poor and near poor covered by Medicaid has dropped from 63% in 1975 to 46% in 1985.[28] Indeed, only

---

27 U.S. Department of H.H.S., P.H.S., N.C.H.S.R., Health Characteristics. According to Family & Personal Income, United States Data from the National Health Survey Series, 10, No. 147, January, 1985.

28 Sources: Unpublished data from Health Care Financing Administration, Office of Management and Budget, Institute for Research on Poverty, and the Brookings Institute. U.S. Department of Commerce, Bureau of the Census, Characteristics of the Population Below Poverty. Current Population Reports. Series P-60, No. 138, March 1983. Money Income and Poverty Status of Families and Persons in the United States, 1983. Current Population Reports. Series P-60, No. 145, August 1984.

39% of the elderly who live on incomes below the poverty line are covered by Medicaid.[29]

What, then, is happening to those who do not have health care? A 1982 study showed that one in six uninsured families reported increased difficulty in obtaining health care for financial reasons and one million families did not get health care for financial reasons.[30]

---

29 Howell, Corder, and Dobson, "Out of Pocket Health Expenses For Medicaid Recipients & Low Income Persons 1980." National Medical Care Utilization & Expenditure Survey. Series B Descriptive Report #4. DHHS Pub. #85-20204. Office of Research & Demonstration, HCFA. Washington, D.C., U.S. Government Printing Office, August 1985.

30 Updated Report on Access to Health Care for American People, Special Report, No. One, Princeton, N.J.: The Robert Wood Johnson Foundation (1983).

The increase in the number of uninsured has put a tremendous strain on providers that traditionally serve the poor. Only ten percent of the nation's hospitals provide forty percent of all hospital care for the poor.[31] These hospitals have been under stress because of the increase in the number of uninsured and because other facilities are no longer doing their fair share of serving this population. Market pressures, such as negotiated lower rates to hospitals from insurance companies, and lower rates as a result of the prospective payment system utilized by the Medicare program have resulted in

---

31 Feder, Judith et al., "Falling Through the Cracks: Poverty, Insurance Coverage & Hospital Care for the Poor 1980 & 1982." Milbank Memorial Fund Quarterly Health & Society, 62(4): 544-566, Fall 1984.

many hospitals turning away uninsured patients. The problem of "dumping" uninsured patients on to primarily public hospitals has reached epidemic proportions. In Chicago, Cook County General Hospital reported that transfers to its emergency room increased 1000%.[32] Dallas' Parkland Memorial Hospital[33] and D.C. General in Washington, D.C. each reported a 400% increase.[34] At Highland General Hospital in Alameda County, California, 85% of the people whose

---

32 Bernard, "Patient Dumping: A Resident's Firsthand View" 34 The New Physician, 323 (October, 1985).

33 Statement of Ray Newman, Executive Vice President and Chief Operating Officer, Dallas County Hospital District before the Subcommittee on Health, Committee on Finance, U.S. Senate, Sept. 28, 1984, p. 22.

34 Engel, M., "Hospitals Refusing to Admit Poor: Patients Transferred to D.C. General," Washington Post (October 15, 1984).

health was jeopardized by a transfer, were uninsured.[35] Providers no longer want to serve uninsured people, nor will they if they can avoid doing so.

Respondents in this case, the individuals described in Section II-A of this Brief, and numerous medically needy applicants are representative of the uninsured who cannot get health care. They do not have the income or resources to purchase private insurance. They are totally dependent on what the state and federal government can provide to help them survive. As shown in Section II, a six month spenddown in the Medicaid program seriously hinders their ability to get the medical care they need. A six

---

35 Annas, George J., "Your Money or Your Life: 'Dumping' Uninsured Patients from Hospital Emergency Wards," American Journal of Public Health," Vol. 76, No. 1, January, 1986.

month spenddown places them in the position of choosing between medical care or food and other necessities of life.

CONCLUSION

A one month spenddown will aid Respondents and those similarly situated in obtaining the only access to health care that is available to them. A one month spenddown is legally required, administratively workable, and essential to the health and well-being of the Respondents, amici Allen and Ignotz, and thousands of other poor people in this country. Amici urge this Court to find for Respondents in this case, to uphold the decision of the Supreme Judicial Court for the Commonwealth of Massachusetts, and to order the

Petitioner to implement a one month spenddown in Massachusetts' medically needy Medicaid program.